

THE STATE OF NEW HAMPSHIRE  
DEPARTMENT OF LABOR  
SPAULDING BUILDING  
95 PLEASANT STREET  
CONCORD, NEW HAMPSHIRE

**NOTICE OF ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE 8aWCA**  
(Please print or type)

To \_\_\_\_\_ Phone # \_\_\_\_\_  
(Name of **Employer**)

\_\_\_\_\_  
(Business Name and Address)

**IN ACCORDANCE WITH RSA 281-A:20**, This is to notify you that an injury occurred.

\_\_\_\_\_  
(Name of Injured **Employee**) SS # \_\_\_\_\_

\_\_\_\_\_  
(Address of Injured Employee) Daytime Phone # \_\_\_\_\_

\_\_\_\_\_  
(Date of Accident or First Treatment)

\_\_\_\_\_  
(Place Accident Happened)

Describe your injury or disease, and how it happened. Identify the body part(s) affected. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have been unable to work since my injury. \_\_\_\_\_  
Yes No

I have incurred the following medical bills.

_____	_____	_____
Name of Doctor	Dates of Service	Amount
_____	_____	_____
Name of Hospital	Dates of Service	Amount
_____	_____	_____
Other	Dates of Service	Amount
_____	_____	_____

\_\_\_\_\_  
(Employer's Signature) (Employee's Signature)

\_\_\_\_\_  
(Date) (Date)

**This form can be returned to DOL with or without employer's signature.**

**NOTICE TO EMPLOYER**

YOU MUST FILE AN EMPLOYER'S FIRST REPORT, Form No. 8WC, WITH THE LABOR COMMISSIONER AND THE NEAREST CLAIMS OFFICE OF YOUR INSURANCE CARRIER, AS SOON AS POSSIBLE AFTER ACQUIRING KNOWLEDGE OF THE OCCURRENCE OF AN OCCUPATIONAL INJURY OR DISEASE TO ONE OF YOUR EMPLOYEES OR UPON PRESENTATION OF THIS NOTICE BY HIM, BUT NO LATER THAN FIVE DAYS THEREAFTER. FAILURE TO COMPLY CARRIES AN AUTOMATIC CIVIL PENALTY OF UP TO \$2500. (RSA 281-A:53)